To the Editor:

We thank the numerous physicians who have written letters and called us on the telephone to convey their comments regarding the two articles on bronchoscopy practice in North America. An overwhelming majority of letters and comments have been exceedingly complimentary. Many have suggested that the ACCP survey should be repeated within the next five years with more questions involving bronchoscopy topics not covered in the survey.1 We commend Drs Anders and Johnson for their study on the role of fluoroscopy in transbronchial lung biopsy (TBLB).2 We have no disagreement with their comments. However, we point to a survey of 231 bronchoscopists in the United Kingdom, which noted that the incidence of pneumothorax after TBLB was 1.8 percent when fluoroscopy was used but significantly increased to 2.9 percent without fluoroscopy.3 Our editorial4 stated that "we highly recommend the use of fluoroscopy because of the level of confidence it provides the bronchoscopist in selecting the maximally abnormal areas for biopsy. Also, fluoroscopic guidance permits precise placement of the forceps in the periphery of the lung for TBLB near the pleura." We recognize the fact that in medical centers where fluoroscopy facilities are not available to the bronchoscopist, TBLB may have to be performed without fluoroscopy, as is the case in many medical centers in North America and many countries. In patients with uniformly diffuse lung disease, TBLB without fluoroscopic guidance can be performed because the precise localization of the lung segment may not be important in obtaining the biopsy specimen. However, if fluoroscopy is easily available, the bronchoscopist is better off using it. Although the recommendation in our editorial is perhaps more applicable to localized infiltrates in the periphery of the lung, the assurance provided by fluoroscopy during and after TBLB may preclude routine post-TBLB chest roentgenography and hospitalization. If patients are routinely subjected to chest roentgenography (by 79 percent of ACCP survey participants) or hospitalization (by 12 percent of ACCP survey participants) after TBLB solely because of not using fluoroscopy (we do not imply that routine hospitalization and chest roentgenography by the ACCP survey participants were due to lack of fluoroscopy facilities), then such a procedure is not cost-effective. We agree that this is an important question and should be included in the next ACCP survey.

The short study by Dr Berger and colleagues is praiseworthy. It appears that they studied the acceptability by patients of topical anesthetic agents on the oropharynx and larynx, but not the tracheobronchial tree. We point out that topical anesthesia in bronchoscopy involves topical application of the anesthetic agent, in addition to nasal passage, to two different areas, namely, the oropharyngolaryngeal structures and the tracheobronchial tree. Once the oropharynx and larynx are adequately anesthetized, the topical anesthetic of choice for anesthetizing the tracheobronchial tree is lidocaine. Our review of the English-language literature from 1966 through 1991 revealed more than 200 articles on topical anesthesia for bronchoscopy; more than 95 percent of the articles discussed the role of lidocaine as the main or the only topical anesthetic. As to the topical anesthetic of choice for the oropharynx and larynx, lidocaine and benzocaine are equally effective, but neither is without a certain unpleasant taste. Lidocaine has a bitter taste, whereas benzocaine produces a "hot" sensation in the throat immediately after it is sprayed. We concur with Dr Berger and his colleagues that topical anesthesia is an important subject and should be included in the next ACCP survey.

Dr McCaughan's statements are exceptionally confusing and alarmingly misleading and erroneous! It makes no clinical sense to bronchoscope a patient without chest roentgenologic abnormality, respiratory symptoms, or other indications for bronchoscopy. It is scientifically absurd to compare chest roentgenography to supine films of the abdomen, and bronchoscopy to colonoscopy, in the diagnosis of cancer of the lung and colon. The fact that a patient had a previous lung tumor is not an indication for routine periodic bronchoscopy unless clinical, roentgenologic, cytologic (sputum), and other findings warrant it. We are unaware of scientific evidence to support the statement that "endobronchial tumors migrate down the path of least resistance..." If the tumor is found early and is confined to the distal bronchus, the best treatment for non-small cell bronchogenic carcinoma in the 1990s is surgical resection, not laser and/or photodynamic therapy, unless the patient cannot undergo surgical resection. The single case report on the use of photodynamic therapy for control of hemoptysis is just that, a solitary anecdote.

Lastly, Dr McCaughan's concluding statement is totally wrong, unjustified, and irresponsible since nowhere in the two articles did we state or indicate that which he alleges.

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REFERENCES

Gunshot Wounds to the Heart
Utility of Transesophageal Echocardiography in Assessment

To the Editor:

I noted with interest the article by Brathwaite et al.,1 which appeared in the January 1992 issue of Chest. This was a case report regarding multiple traumatic gunshot wounds of the heart assessed by transesophageal echocardiography (TEE). The authors state that "although TEE has become routine in cardiology and cardiac surgery in many centers, its use in the cardiac trauma patient has not been explored." I would like to bring to your attention an article published in 1989, in which TEE together with transthoracic and epicardial echocardiography was utilized to assess four patients and eight mongrel dogs with intracardiac foreign bodies, some of which were gunshot wounds.4 This article also concluded that TEE has substantial utility in detecting intracardiac foreign objects resulting from gunshot wounds.

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REFERENCES